STATE OF CALIFORNIA —HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

FOOD STAMP PROGRAM
REQUEST FOR REGULATION INTERPRETATION

INSTRUCTIONS: Complete items 1 - 10 on the form. Use a separate form for each policy interpretation request. Retain a copy of the FS 24 for your records. For counties asking for policy interpretations, submit the question directly to a FRAT representative via e-mail. For other organizations (e.g., Quality Control, Administrative Law Judges), submit questions directly to the Food Stamp Policy Implementation Unit or Employment and Special Projects Unit representative via e-mail.

1. RESPONSE NEEDED DUE TO:
   - ☐ Policy/Regulation Interpretation
   - ☐ QC
   - ☐ Fair Hearing
   - ☐ Immediate Need/Emergency Services
   - ☐ Other:

2. REQUESTOR NAME:

3. PHONE NO.:

4. REGULATION CITE(S):
   63-502.33

5. DATE OF REQUEST:
   3/21/2012

   NEED RESPONSE BY:
   asap

6. COUNTY/ORGANIZATION:
   State Hearings Division

7. SUBJECT:
   Excess Medical Deduction

8. REFERENCES: *(Include ACL/ACIN, court cases, etc. in references)*
   NOTE: All requests must have a regulation cite(s) and/or a reference(s).

9. QUESTION: (INCLUDE SCENARIO IF NEEDED FOR CLARITY):

I am reviewing a decision in which the claimant -- 69 years old -- has requested a rehearing of a discontinuance of his Calfresh benefits due to his income exceeding the net income limit. His net income was determined to be $966.25/mo,, in excess of the $908.00/mo limit.

The claimant submitted into evidence copies of out-of-pocket drug copayments averaging $90/mo and medical provider copayments averaging $239/mo. In addition to the Medicare premium, the judge allowed the $90/mo drug copayment as a medical deduction but not the provider copayments, on the basis that the Medicare statements indicate that the claimant "may be billed" for the copayment, therefore, it is insufficient evidence to establish that the claimant is obligated to pay any additional amount for provider services.

In the claimant's rehearing, he argues that even if he doesn't ultimately pay the entire copayment, it is unknown at the time of billing, h

10. REQUESTOR'S PROPOSED ANSWER:

11. FRAT RESPONSE TO COUNTY QUESTION:

12. STATE POLICY RESPONSE *(FSPIU USE ONLY)*:

1. Medicare coverage is addressed in 63-503.251(b)(1)(b):
When the bill is submitted and the eligible household member is covered by Medicare or BlueCross/Blue Shield, or private insurance company, 20 percent of the total bill shall be the household's medical cost.
A deduction shall be allowed only for the month the expense is billed or otherwise becomes due, regardless of when the household intends to pay the expense. Rent which is due each month shall be included in the household's shelter expenses, even if the household has not yet paid the expense. Amounts carried forward from past billing periods shall not be deducted, even if included with the most recent billing and actually paid by the household. In any event, an allowable expense shall be deducted only once.
2. Households may elect to have fluctuating expenses averaged. 63-503.252(a) reads:
Households reporting medical expenses, (as specified....) during their certification period, with no specified payment schedule, may elect to have a one-time only deduction or to have the expense averaged over the remaining months of their certification period.

FOR FRAT USE

DATE RECEIVED:	DATE RESPONDED TO COUNTY:	DATE FORWARDED TO STATE:
	TA	

FS 24 (8/08)

9, QUESTION: (INCLUDE SCENARIO IF NEEDED FOR CLARITY): (Continued)

In the claimant's rehearing, he argues that even if he doesn't ultimately pay the entire copayment, it is unknown at the time of billing, he is legally obligated to pay the entire amount and, therefore, it should be treated as a medical expense.

My questions are the following: 1. Are Medicare copayments considered to be a potential excess medical deduction. They are not specifically listed in the regulation as an example; and 2. if they are potentially a medical deduction, how are they treated? In this case, the judge found that the claimant submitted evidence to establish that he actually paid a total of $2,637.49 in 2011, or an average of $239.77. In reviewing these copayments, they are a combination of outpatient, Part B, and DME claim types, and vary significantly from month to month.